INLAND COUNTIES EMERGENCY MEDICAL AGENCY
Serving San Bernardino, Inyo and Mono Counties
1425 SOUTH "D" STREET
SAN BERNARDINO, CA 92415-0060
(909) 388-5823 FAX: (909) 388-5825

FLIGHT NURSE AUTHORIZATION

Check (✓) the appropriate box

☐ **Initial Authorization ($45.00)** **ICEMA Flight Nurse Authorization #:**_____

☐ **Continuous Authorization ($45.00)** **Exp Date:**_____

FEES ARE NONREFUNDABLE - CASH OR MONEY ORDER ONLY- NO PERSONAL CHECKS ACCEPTED

Legal Name: _____
Last First Middle Sex(M/F)

Address: _____
Home Address City State Zip

_____
Mailing Address (if different) City State Zip

Date of Birth: _____ Phone #: _____ Drivers License # _____

SSN #: _____ EMS Aircraft Employer: _____

Email Address:_____ *(for ICEMA use only, will not be given out to third parties)*

VERIFICATION OF EMPLOYMENT AS A FLIGHT NURSE IN THE ICEMA REGION

To be completed by the EMS Coordinator at an ICEMA authorized EMS Aircraft Provider

This verifies that the applicant named above, California RN License # _____ is currently/or will be employed as a Flight Nurse at:_____ . This also verifies the applicant completed the (4 hrs) Flight Nurse Orientation Course *(Initial only)* on _____(Date)

_____
Authorized Signature **Title** **Date**

I hereby certify under penalty of perjury that all information on this application is true and correct to the best of my knowledge and belief, and I understand that any falsification or omission of material facts may cause forfeiture on my part of all rights to Flight Nurse Authorization in the ICEMA region. I understand all information on this application is subject to verification, and I hereby give my express permission for ICEMA to contact any person or agency for information related to the authorization process. I agree to hold ICEMA harmless from any act or action resulting from the release of the information as stated above.

_____
Signature of Applicant **Date**

ICEMA USE ONLY: Done By:*(Initials)*_____ Photo:_____ Authorization # _____

CA RN License #:_____ Exp. Date_____/_____/_____ Effective: ____/____/___

ACLS Exp:____/____DL#:_____cc to employer:_____ Exp. Date: ____/____/___

Accounting #: _____